

NURSE AIDE TRAINING STATISTICAL INFORMATION

| | | | |
|---------------|--------------------------|---------------------------|----------|
| Provider Name | Medicaid Provider Number | Reporting Period From: | Through: |
|---------------|--------------------------|---------------------------|----------|

ONLY NURSING FACILITIES MUST COMPLETE THIS ATTACHMENT.

| Description | JANUARY 1 through MARCH 31 (1) | APRIL 1 through JUNE 30 (2) | JULY 1 through SEPTEMBER 30 (3) | OCTOBER 1 through DECEMBER 31 (4) | TOTAL (Col. 1 thru 4) (5) |
|---|---|--------------------------------------|--|--|---------------------------------|
| SECTION A: NURSE AIDE CONTINUING EDUCATION | | | | | |
| 1. Number of Nurse Aides completing Continuing Education | | | | | |

| SECTION B: NUMBER OF AIDES TRAINED | NUMBER OF NURSE AIDES | | | | |
|--|-------------------------------------|--|--|--|--------------------------------------|
| | TRAINED IN THIS FACILITY | | TRAINED IN OTHER LTCFs (3) | TRAINED FROM OTHER SOURCES (4) | TOTAL (Sum of col. 1-4) (5) |
| | Your Facility Nurse Aides (1) | Other Facilities Nurse Aides (2) | | | |
| 2. Number of aides who completed training during cost report period. | | | | | |
| 3. Number of aides who dropped out of training during the cost report period. | | | | | |
| 4. Total aides (sum of lines 2 and 3) | | | | | |
| 5. Total number of state approved nurse aides on your payroll at the end of the cost report period. | | | | | |
| 6. Total number of state approved nurse aides, excluding line 5, at the end of the cost report period. | | | | | |

WAGE AND HOURS SURVEY

| | | |
|---------------|--------------------------|------------------------------------|
| Provider Name | Medicaid Provider Number | Reporting Period From: Through: |
|---------------|--------------------------|------------------------------------|

INSTRUCTIONS:

REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED.

Column (C): Enter total wages paid to facility personnel (This must agree with each account on schedules B-1, B-2, & C Column)

Column (D): Enter total wages paid to an owner of the facility as reported on C-2 (This must agree with Schedule C-2).

Column (E): Column (C) minus Column (D).

Column (F): Enter total hours that correspond with the total wages reported in column (C).

Column (G): Enter total hours that correspond with the total wages reported in column (D).

Column (H): Column (F) minus column (G).

| WAGE COST CENTERS (A) | Chart of Acct (B) | Total Wages Paid (C) | Owners Wages Paid (D) | Total Non-owner Wages Paid (E) | Total Hours Paid (F) | Owners Hours Paid (G) | Total Non-owner Hours Paid (H) |
|---|----------------------------|-------------------------------|--------------------------------|---|-------------------------------|--------------------------------|---|
| OTHER PROTECTED COSTS | | | | | | | |
| 1. Water and Sewage (salary only) | 6030 | | | | | | |
| 1a. EAP Administrator - Other Protected | 6057 | | | | | | |
| 1b. Self Funded Programs Admn. - Other Protected | 6058 | | | | | | |
| 1c. Staff Development - Other Protected | 6059 | | | | | | |
| 1d. TOTAL Other Protected Costs Sum of lines (1 thru 4) | | | | | | | |
| DIRECT CARE NURSING AND HABILITATION/REHABILITATION | | | | | | | |
| 2. Medical Director | 6100 | | | | | | |
| 3. Director of Nursing | 6105 | | | | | | |
| 4. RN Charge Nurse | 6110 | | | | | | |
| 5. LPN Charge Nurse | 6115 | | | | | | |
| 6. Registered Nurse | 6120 | | | | | | |
| 7. Licensed Practical Nurse | 6125 | | | | | | |
| 8. Nurse Aides | 6130 | | | | | | |
| 9. Activity Director | 6135 | | | | | | |
| 10. Activity Staff | 6140 | | | | | | |
| 11. Recreational Therapist for NFs | 6145 | | | | | | |
| 12. Program Specialist for ICFs-MR | 6150 | | | | | | |
| 13. Program Director | 6155 | | | | | | |
| 14. Habilitation Supervisor for NFs | 6160 | | | | | | |
| 15. Habilitation Supervisor for ICFs-MR | 6165 | | | | | | |
| 16. Habilitation Staff | 6170 | | | | | | |
| 17. Psychologist | 6175 | | | | | | |
| 18. Psychology Assistant | 6180 | | | | | | |
| 19. Respiratory Therapist | 6185 | | | | | | |
| 20. Social Work/Counseling | 6190 | | | | | | |
| 21. Social Services/Pastoral Care | 6195 | | | | | | |
| 22. Qualified Mental Retardation Professional | 6200 | | | | | | |
| 23. Quality Assurance | 6205 | | | | | | |
| 24. Other Direct Care (salary) | 6220 | | | | | | |
| Home Office Costs/Direct Care (salary) | 6230 | | | | | | |
| 26. TOTAL Nursing and Habilitation/ Rehabilitation (sum of lines 6 through 25) | | | | | | | |
| 27. TOTAL Page 1 (sum of lines 1d and 26) | | | | | | | |

APPROVAL DATE MAY 28 1998

Attachment 4.19D
Page 62 of 65

AD 5005
PAGE 62 OF 65
5101:3-3-202
Page 62 of 65

Appendix A
Enacted

Page 33
ODHS 2524
Attachment 6
2 of 3

WAGE AND HOURS SURVEY

| Provider Name | | Medicaid Provider Number | | Reporting Period | | | |
|--|----------------------|--------------------------|--------------------------|-----------------------------------|-------------------------|--------------------------|-----------------------------------|
| | | | | From: | Through: | | |
| WAGE COST CENTERS (A) | Chart of Acct (B) | Total Wages Paid (C) | Owners Wages Paid (D) | Total Non-owner Wages Paid (E) | Total Hours Paid (F) | Owners Hours Paid (G) | Total Non-owner Hours Paid (H) |
| NURSING FACILITIES ONLY | | | | | | | |
| NURSE AIDE TRAINING | | | | | | | |
| 32 In-House Trainer Wages | 6400 | | | | | | |
| 33 Classroom Wages: Nurse Aides | 6410 | | | | | | |
| 34 Clinical Wages: Nurse Aides | 6420 | | | | | | |
| 35 TOTAL Nurse Aide Training - NFs (sum of lines 32 through 34) | | | | | | | |
| ICF's-MR FACILITIES ONLY | | | | | | | |
| DIRECT CARE THERAPIES | | | | | | | |
| 36 Physical Therapist ICF-MR | 6600 | | | | | | |
| 37 Physical Therapy Assistant ICF-MR | 6605 | | | | | | |
| 38 Occupational Therapist ICF-MR | 6610 | | | | | | |
| 39 Occupational Therapy Assistant ICF-MR | 6615 | | | | | | |
| 40 Speech Therapist ICF-MR | 6620 | | | | | | |
| 41 Audiologist ICF-MR | 6630 | | | | | | |
| 42 TOTAL Direct Care Therapies ICF-MR (sum of lines 36 through 41) | | | | | | | |
| NFs and ICFs-MR | | | | | | | |
| PAYROLL-TAX, FRINGE BEN. & STAFF DEVELOPMENT (No Purchased Nursing) | | | | | | | |
| 43 EAP Administrator - Direct Care | 6535 | | | | | | |
| 44 Self Funded Programs Admin. - Direct Care | 6540 | | | | | | |
| 45 Staff Development - Direct Care | 6550 | | | | | | |
| 46 TOTAL Fringe Benefits & Staff Development (sum of lines 43 through 45) | | | | | | | |
| DIETARY COST | | | | | | | |
| 47 Dietitian | 7000 | | | | | | |
| 48 Food Service Supervisor | 7005 | | | | | | |
| 49 Dietary Personnel | 7015 | | | | | | |
| 50 EAP Administrator - Dietary | 7075 | | | | | | |
| 51 Self Funded Programs Admin. - Dietary | 7080 | | | | | | |
| 52 Staff Development - Dietary | 7090 | | | | | | |
| 53 TOTAL Dietary Cost (sum of lines 47 through 52) | | | | | | | |
| HABILITATION and PHARMACEUTICAL | | | | | | | |
| 54 Medical/Habilitation Records | 7105 | | | | | | |
| 55 Pharmaceutical Consultant | 7110 | | | | | | |
| 56 TOTAL Habilitation, Pharmaceutical (sum of lines 54 and 55) | | | | | | | |
| 57 TOTAL Page 28, 35, 42, 49, 52 (sum of lines 35, 42, 48, 55 and 56) | | | | | | | |

ODHS 2524 (REV. 8/97)

TN # 91-02 APPROVAL DATE

SUPERSEDES

MAY 28 1998

TN # 91-05 EFFECTIVE DATE 3/31/98

Substituted

5101.3-3-202
Page 83 of 65Appendix A
EnactedAttachment 4.19D
Page 63 of 65 Page 34
ODHS 2524
Attachment 6
3 of 3

WAGE AND HOURS SURVEY

| Provider Name | | Medicaid Provider Number | Reporting Period | | | | |
|---|----------------------------|-------------------------------|--------------------------------|---|-------------------------------|--------------------------------|---|
| | | | From: | Through: | | | |
| WAGE COST CENTERS (A) | Chart of Acct (B) | Total Wages Paid (C) | Owners Wages Paid (D) | Total Non-owner Wages Paid (E) | Total Hours Paid (F) | Owners Hours Paid (G) | Total Non-owner Hours Paid (H) |
| ADMINISTRATIVE & GENERAL SERVICES | | | | | | | |
| 54-58 Administrator | 7200 | | | | | | |
| 55-59 Other Administrative Personnel | 7210 | | | | | | |
| 56-60 Security Services (salary only) | 7230 | | | | | | |
| 57-61 Laundry/Housekeeping Supervisor | 7240 | | | | | | |
| 58-62 Housekeeping | 7245 | | | | | | |
| 59-63 Laundry and Linen | 7250 | | | | | | |
| 60-64 Accounting | 7265 | | | | | | |
| 61-65 Data Services (salary only) | 7285 | | | | | | |
| 62-66 Other Indirect Care (salary) | 7305 | | | | | | |
| 63-67 Home Office Costs/Indirect Care (salary) | 7310 | | | | | | |
| 64-68 TOTAL Administrative & General Services (sum of lines 58 through 67) | | | | | | | |
| MAINTENANCE AND MINOR EQUIPMENT | | | | | | | |
| 69-70 Plant Operations/Maintenance Supervisor | 7320 | | | | | | |
| 70-71 Plant Operations and Maintenance | 7330 | | | | | | |
| 71-72 TOTAL Maintenance and Minor Equipment (sum of lines 69 and 70) | | | | | | | |
| PAYROLL TAXES, FRINGE BENEFITS & STAFF DEVELOPMENT | | | | | | | |
| 72-73 EAP Administrator - Indirect Care | 7525 | | | | | | |
| 73-74 Self Funded Prog. Admin. - Indirect Care | 7530 | | | | | | |
| 74-75 Staff Development - Indirect Care | 7535 | | | | | | |
| 75-76 TOTAL Payroll Taxes, Fringe Benefits & Staff Development (sum of lines 72 thru 74) | | | | | | | |
| 76-77 TOTAL Page 3 (sum of lines 68, 71 and 76) | | | | | | | |
| 77-78 TOTAL ATTACHMENT 6 Pages 1, 2 and 3 (sum of lines 31, 51 and 76) | | | | | | | |

ODHS 2524 (REV. 6/97)

 TN # 76-02 APPROVAL DATE MAY 28 1998
 SUPERSEDES
 TN # 97-05 EFFECTIVE DATE 3/31/98

Substituted Page

ADDENDUM FOR DISPUTED COSTS

| | | |
|---------------|--------------------------|------------------------------------|
| Provider Name | Medicaid Provider Number | Reporting Period From: Through: |
|---------------|--------------------------|------------------------------------|

INSTRUCTIONS: This attachment is for the reporting of costs as specified in the Ohio Revised Code, Section 5111.26, that the provider believes should be classified differently than required on the cost report.

1. Enter in the "Reclassification From:" columns, the specific account title and chart number as entered on the cost report, as well as, costs applicable to columns 1 through 3.
2. Enter in the "Reclassification To:" columns, the schedule, line number, and reason you believe these costs should be reclassified.

| Reclassification From: | | | | | Reclassification To: | | |
|--|----------------|--------------------------|-----------------------|---------------------------|----------------------|------|--------|
| CURRENT COST CENTERS | Chart of Acct. | Salary Facility Employed | Other/ Contract Wages | Adjusted/ Allocated Total | Schedule | Line | REASON |
| | | (1) | (2) | (3) | (4) | (5) | (6) |
| OTHER PROTECTED COSTS | | | | | | | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. TOTAL Other Protected Costs (sum of lines 1 through 4) | | | | | | | |
| DIRECT CARE COST CENTER | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |
| 9. | | | | | | | |
| 10. TOTAL Direct Care Costs (sum of lines 6 through 9) | | | | | | | |
| INDIRECT CARE COST CENTER | | | | | | | |
| 11. | | | | | | | |
| 12. | | | | | | | |
| 13. | | | | | | | |
| 14. | | | | | | | |
| 15. TOTAL Indirect Care Costs (sum of lines 11 through 14) | | | | | | | |
| NON-REIMBURSABLE EXPENSES | | | | | | | |
| 16. | | | | | | | |
| 17. | | | | | | | |
| 18. | | | | | | | |
| 19. | | | | | | | |
| 20. TOTAL Non-Reimbursable Expen (sum of lines 16 through 19) | | | | | | | |
| CAPITAL COST CENTER | | | | | | | |
| 21. | | | | | | | |
| 22. | | | | | | | |
| 23. | | | | | | | |
| 24. | | | | | | | |
| TOTAL Capital Cost | | | | | | | |
| 26. TOTAL COST CENTERS (sum of lines 5,10,15,20, and 25) | | | | | | | |

5101:3-3-202
Page 65 of 65

REPLACES RULE 5101:3-3-202

EFFECTIVE DATE: _____

CERTIFICATION: _____

DATE

PROMULGATED UNDER: RC CHAPTER 119.

STATUTORY AUTHORITY: RC SECTION 5111.02

RULE AMPLIFIES: RC SECTIONS 5111.01, 5111.02, 5111.26

PRIOR EFFECTIVE DATES: 12/30/77, 8/3/79, 7/1/80, 1/19/84, 3/29/85, 12/31/87 (EMER.),
3/30/88, 7/1/88, 12/20/88, (EMER.), 3/18/89, 12/28/89 (EMER.), 3/22/90, 10/1/90 (EMER.), 12/31/90, 10/1/91,
(EMER.), 12/20/91, 12/30/91 (EMER.), 3/19/92, 6/30/92, 12/1/92, 6/26/93,
12/30/93 (EMER.), 3/18/94, 12/31/94, 12/28/95, 3/20/97 (EMER.), 5/22/97.

REVIEW DATE: _____

5101:3-3-02 APPROVAL DATE MAY 28 1998
SUPERSEDES
5101:3-3-02 EFFECTIVE DATE 8/31/98

5101:3-3-21
Page 1 of 3

5101:3-3-21 AUDITS OF NURSING FACILITIES (NF) AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF-MR).

- (A) THE OHIO DEPARTMENT OF HUMAN SERVICES (ODHS) MAY CONDUCT AUDITS OF THE ODHS 2524 MEDICAID NF AND ICF-MR COST REPORT IN ACCORDANCE WITH CHAPTER 119. OF THE REVISED CODE, AND SHALL NOTIFY THE NF OR ICF-MR OF ITS AUDIT FINDINGS.
- (1) UNTIL AN AUDIT IS CONDUCTED OR UNTIL THREE YEARS HAVE ELAPSED SINCE THE COST REPORT WAS FILED WITH ODHS, WHICHEVER IS EARLIER, A FACILITY MAY AMEND THE COST REPORT AS SET FORTH IN THE FINAL RATE RECALCULATION PROVISION PURSUANT TO SECTION 5111.28 OF THE REVISED CODE AND RULE 5101:3-3-20 OF THE ADMINISTRATIVE CODE. THE AMENDED COST REPORT SHALL BE SUBMITTED TO ODHS IN DUPLICATE ON THE APPROPRIATE ODHS 2524 COST REPORT FORMS.
- (2) ODHS MAY ESTABLISH A CONTRACT FOR THE AUDITING OF FACILITIES BY OUTSIDE FIRMS. EACH CONTRACT ENTERED INTO BY BIDDING SHALL BE EFFECTIVE FOR ONE TO TWO YEARS. ODHS SHALL ESTABLISH AN AUDIT MANUAL AND PROGRAM WHICH SHALL REQUIRE THAT ALL FIELD AUDITS, CONDUCTED EITHER PURSUANT TO A CONTRACT OR BY ODHS EMPLOYEES:
- (a) COMPLY WITH APPLICABLE RULES PRESCRIBED PURSUANT TO TITLE XVIII AND XIX OF THE "SOCIAL SECURITY ACT," 49 STAT. 620 (1935), 42 U.S.C.A. 301, AS AMENDED; AND
- (b) CONSIDER GENERALLY ACCEPTED AUDITING STANDARDS PRESCRIBED BY THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS; AND
- (c) INCLUDE A WRITTEN SUMMARY AS TO WHETHER THE COSTS INCLUDED IN THE REPORT EXAMINED DURING THE AUDIT ARE ALLOWABLE AND ARE PRESENTED FAIRLY IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES AND ODHS RULES, WHETHER IN ALL MATERIAL ASPECTS, ALLOWABLE COSTS ARE DOCUMENTED, REASONABLE, AND RELATED TO PATIENT CARE; AND

TNS # 94-07 APPROVAL DATE JUN 28 1994
SUPERSEDES
TNS # 91-03 EFFECTIVE DATE 10/1/94

- (d) ARE CONDUCTED BY ODHS EMPLOYEES OR ACCOUNTING FIRMS WHO, DURING THE PERIOD OF THE PROFESSIONAL ENGAGEMENT OR EMPLOYMENT AND DURING THE PERIOD COVERED BY THE FINANCIAL STATEMENTS, DO NOT HAVE NOR ARE COMMITTED TO ACQUIRE ANY DIRECT OR INDIRECT FINANCIAL INTEREST IN THE OWNERSHIP, FINANCING, OR OPERATION OF A NURSING FACILITY OR INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED IN THIS STATE; AND
 - (e) ARE CONDUCTED BY ODHS EMPLOYEES OR ACCOUNTING FIRMS WHO, AS A CONDITION OF THE CONTRACT OR EMPLOYMENT, SHALL NOT AUDIT ANY FACILITY THAT HAS BEEN A CLIENT OF THE FIRM OR AN ODHS EMPLOYEE; AND
 - (f) ARE CONDUCTED BY ODHS EMPLOYEES OR AUDITORS WHO ARE OTHERWISE INDEPENDENT AS DETERMINED BY THE STANDARDS OF INDEPENDENCE ESTABLISHED BY THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS; AND
 - (g) ARE COMPLETED WITHIN THE TIME PERIOD SPECIFIED BY ODHS; AND
 - (h) PROVIDE TO THE FACILITY COMPLETE WRITTEN INTERPRETATIONS WHICH EXPLAIN IN DETAIL THE APPLICATION OF ALL RELEVANT CONTRACT PROVISIONS, REGULATIONS, AUDITING STANDARDS, RATE FORMULAE, AND ODHS POLICIES, WITH EXPLANATIONS AND EXAMPLES, THAT ARE SUFFICIENT TO PERMIT THE FACILITY TO CALCULATE WITH REASONABLE CERTAINTY THOSE COSTS THAT ARE ALLOWABLE AND THE RATE TO WHICH THE FACILITY IS ENTITLED.
- (B) ODHS SHALL PREPARE A WRITTEN SUMMARY OF ANY AUDIT DISALLOWANCE SET FORTH IN PARAGRAPH (A) OF THIS RULE. WHERE THE FACILITY IS PURSUING JUDICIAL AND ADMINISTRATIVE REMEDIES IN GOOD FAITH REGARDING THE DISALLOWANCE OR FINDING, ODHS SHALL NOT WITHHOLD FROM THE FACILITY'S CURRENT PAYMENTS ANY AMOUNTS THE DEPARTMENT CLAIMS TO BE DUE FROM THE FACILITY SET FORTH IN THE FINAL RATE RECALCULATION PROVISION PURSUANT TO SECTION 5111.28 OF THE REVISED CODE.

TNS #94-01 APPROVAL DATE JUN 28 1994

SUPERSEDES

TNS #94-03 EFFECTIVE DATE 10/1/94

5101:3-3-21
Page 3 of 3

REPLACES RULE 5101:3-3-27

EFFECTIVE DATE: _____

CERTIFICATION: _____

DATE

PROMULGATED UNDER: RC CHAPTER 119.

STATUTORY AUTHORITY: RC SECTION 5111.02

RULE AMPLIFIES: RC SECTIONS 5111.01, 5111.02, 5111.27, 5111.28

PRIOR EFFECTIVE DATES: 12/30/77, 8/3/79, 7/3/80/, 3/4/83 (EMER.), 6/3/83,
1/19/84, 12/31/84 (EMER.), 4/1/85, 4/1/87, 10/1/91
(EMER.), 12/20/91, 7/1/92 (EMER.), 9/10/92, 9/30/93
(EMER.)

TNS # 94-07 APPROVAL DATE JUN 28 1994
SUPERSEDES
TNS # 94-03 EFFECTIVE DATE 10/1/94

5101:3-3-22
Page 1 of 3

5101:3-3-22

RATE RECALCULATIONS, INTEREST ON OVERPAYMENTS, PENALTIES, REPAYMENT OF OVERPAYMENTS, AND DEPOSIT OF REPAYMENT OF OVERPAYMENTS FOR NURSING FACILITIES (NES) AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFS-MR).

- (A) IF THE PROVIDER PROPERLY AMENDS ITS COST REPORT UNDER RULE 5101:3-3-20 OF THE ADMINISTRATIVE CODE, THE OHIO DEPARTMENT OF HUMAN SERVICES (ODHS) MAKES A FINDING BASED ON AN AUDIT UNDER RULE 5101:3-3-21 OF THE ADMINISTRATIVE CODE, OR ODHS MAKES A FINDING BASED ON AN EXCEPTION REVIEW OF RESIDENT ASSESSMENT INFORMATION CONDUCTED UNDER SECTION 5111.27 OF THE REVISED CODE AFTER THE EFFECTIVE DATE OF THE RATE FOR DIRECT CARE COSTS THAT IS BASED ON THE ASSESSMENT INFORMATION ANY OF WHICH RESULTS IN A DETERMINATION THAT THE PROVIDER HAS RECEIVED A HIGHER RATE THAN IT WAS ENTITLED TO RECEIVE, ODHS SHALL RECALCULATE THE PROVIDER'S RATE USING THE REVISED INFORMATION. ODHS SHALL APPLY THE RECALCULATED RATE TO THE PERIODS WHEN THE PROVIDER RECEIVED THE INCORRECT RATE TO DETERMINE THE AMOUNT OF THE OVERPAYMENT. THE PROVIDER SHALL REFUND THE AMOUNT OF THE OVERPAYMENT. IN ADDITION TO REQUIRING A REFUND UNDER THIS RULE, ODHS MAY CHARGE THE PROVIDER INTEREST AT THE APPLICABLE RATE SPECIFIED IN THIS RULE FROM THE TIME THE OVERPAYMENT WAS MADE.
- (1) IF THE OVERPAYMENT RESULTED FROM COSTS REPORTED FOR CALENDAR YEAR 1993, THE INTEREST SHALL BE NO GREATER THAN ONE AND ONE-HALF TIMES THE AVERAGE BANK PRIME RATE.
- (2) IF THE OVERPAYMENT RESULTED FROM COSTS REPORTED FOR SUBSEQUENT CALENDAR YEARS:
- (a) THE INTEREST SHALL BE NO GREATER THAN TWO TIMES THE AVERAGE BANK PRIME RATE IF THE OVERPAYMENT WAS EQUAL TO OR LESS THAN ONE PER CENT OF THE TOTAL MEDICAID PAYMENTS TO THE PROVIDER FOR THE FISCAL YEAR FOR WHICH THE INCORRECT INFORMATION WAS USED TO ESTABLISH A RATE.

TNS # 94-17 APPROVAL DATE SEP 13 1994
SUPERSEDES
TNS # NEW EFFECTIVE DATE 6/30/94